



## AGENCY WAITING LIST NOTIFICATION FORM

Applicant's name:

First

Last

Mailing address:

Street

City

State

Zip Code

Telephone number:

**Please check the appropriate box below  
regarding how the WIC program will contact you:**

I ☐ do ☐ do not authorize the WIC program to leave voicemail messages at the phone number I provide to WIC.

I understand messages may contain information including but not limited to the WIC program name, applicant, participant and/or family name(s) and information related to appointments.

This section is for **CLINIC USE** only:

1. Date placed on waiting list: \_\_\_\_\_

2. Please circle one of the following options:

a. Potential / Actual Priority:

I II III IV V VI

b. Potential / Actual Category:

P B N I C

3. Complete a, b, or c as applicable:

a. P—EDC: \_\_\_\_\_

b. I/C—DOB: \_\_\_\_\_

c. N/B—Date pregnancy ended: \_\_\_\_\_

4. Referral to health and/or food/public assistance Program provided: \_\_\_\_\_

5. Date/time of appt for screening (if applicable): \_\_\_\_\_

**It has been determined that you may meet the criteria to participate in the Idaho WIC program. Unfortunately, at this time funding is not available to provide services to all the applicants who may qualify. You are being placed on a waiting list and will be notified when it is possible for you to apply for program benefits.**

**You may appeal this decision by requesting a Fair Hearing. The request for a Fair Hearing must be made in writing within 60 days of the date of this letter. You may contact the local agency WIC Coordinator to request a form (CFR 246.9 Fair Hearing Procedures).**

The U.S. Department of Agriculture prohibits discrimination against its customers, employees, and applicants for employment on the bases of race, color, national origin, age, disability, sex, gender identity, religion, reprisal, and where applicable, political beliefs, marital status, familial or parental status, sexual orientation, or all or part of an individual's income is derived from any public assistance program, or protected genetic information in employment or in any program or activity conducted or funded by the Department. (Not all prohibited bases will apply to all programs and/or employment activities.) If you wish to file a Civil Rights program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, found online at [http://www.ascr.usda.gov/complaint\\_filing\\_cust.html](http://www.ascr.usda.gov/complaint_filing_cust.html), or at any USDA office, or call (866) 632-9992 to request the form. You may also write a letter containing all of the information requested in the form. Send your completed complaint form or letter to us by mail at U.S. Department of Agriculture, Director, Office of Adjudication, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410, by fax (202) 690-7442 or email at [program.intake@usda.gov](mailto:program.intake@usda.gov). Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish). USDA is an equal opportunity provider and employer.

X

Signature of Applicant and/or Responsible Adult

Date

X

Signature and Title of Clinic Staff

Date



## A. LOCAL AGENCY WAITING LIST: Transferring Clients (VOC)

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Category ( P B N I C )	Appt. date/time	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

The WIC Program is an equal opportunity provider and employer



## B. LA WAITING LIST PRIORITY LEVEL I: Medical - P, B, and I

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size & income	Category/ Infant age/DOB and/or EDC	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

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SUPPLEMENTAL NUTRITION PROGRAM  
FOR WOMEN, INFANTS & CHILDREN

4/2013

### C. LA WAITING LIST PRIORITY LEVEL II: Infant of WIC Mom

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Infant age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

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4/2013

## D. LA WAITING LIST PRIORITY LEVEL III: Medical - Children

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Child age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

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## E. LA WAITING LIST PRIORITY LEVEL IV: Nutrition – Homeless (H), Migrant (M), P, B, and I

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Category/ Infant age/DOB and/or EDC	Appt. date/time (if applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

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4/2013

## F. LA WAITING LIST PRIORITY LEVEL V: Nutrition – Homeless (H), Migrant (M) and C

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Child age/DOB	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason

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## G. LA WAITING LIST PRIORITY LEVEL VI: Nutrition & Medical – Homeless (H), Migrant (M) and N

Initial contact date	Date placed on waitlist	Applicant's Name	Telephone # and Address	Household size/income	Date pregnancy ended	Appt. date/time (If applicable)	Comments	Staff initials	Date notified of status	Date off waitlist/ Reason



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